STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G377	A. BUILDING 00 B. WING	01/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CORVILLA INC	52549 MYRTLE ST SOUTH BEND, IN 46637

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W 0000 Bldg. 00	This visit was for the Post Certification Revisit (PCR) to the predetermined full recertification and state licensure survey and the COVID-19 focused infection control survey completed on 9/1/2021. Dates of Survey: January 3, 4, 5, and 6, 2022. Facility Number: 000891 Provider Number: 15G377 Aims Number: 100244320 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 1/12/22.	W 0000		
W 0159 Bldg. 00	483.430(a) QIDP Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional who- Based on record review and interview for 3 of 3 sample clients (#1, #2, and #3), the Qualified Intellectual Disabilities Professional failed to effectively coordinate, integrate, and monitor clients #1, #2, and #3's active treatment programs. The QIDP failed to ensure clients #1 and #2 had Comprehensive Functional Assessments (CFAs) completed within 30 days of admission, to develop Individual Support Plans (ISPs) for clients #1 and #2 within 30 days of admission, and to ensure client #3's goals were implemented and recorded as indicated in his ISP. Findings include:	W 0159	It is a requirement that all SGL staff provide active treatment and goal documentation for all clients served. Beginning 01/21/2022 Managers, QIDP, and Director of Residential Services will monitor the implementation of goals at least 1x weekly via therap programmatic reports. Reports will be run by all Corvilla managers each Monday and Corvilla QIDP/DRS each Friday. If necessary, disciplinary action	01/21/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	1. The QIDP failed to ensure clients #1 and #2 had CFAs completed within 30 days of admission. Please see W210. 2. The QIDP failed to develop ISPs for clients #1 and #2 within 30 days of admission. Please see W226. 3. The QIDP failed to ensure client #3's goals were implemented and recorded as indicated in his ISP. Please see W252. This deficiency was cited on 9/1/21. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-3(a)		will be taken for failure to perform/document client ISP goals. In addition, 1x weekly administrative staff (CCQA, DRS, QIDP, LPN, HWC) will make scheduled observation visits to each Corvilla group home to ensure active treatment is being completed(Please see attached Observation Checklist)	
W 0192 Bldg. 00	483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. Based on observation, record review, and interview for 1 of 3 sample clients (#1), the facility failed to ensure staff were adequately trained to address client #1's health care needs. Findings include: 1. An observation was conducted at the group home on 1/3/22 from 7:00 am through 8:15 am. Client #1 was present in the home for the duration of the observation period. On 1/3/22 at 7:56 am, House Manager (HM) #1 put on gloves and used a syringe to check client #1's g-tube (gastrostomy tube) for residual. HM #1 attached a syringe to client #1's g-tube and pulled	W 0192	It is a requirement that SGL staff are trained on all risks plans for clients served. Agency nurse will retrain all Corvilla staff on risk plans for clients served. In addition, RN will train Myrtle staff on GTube specific training. 1x weekly administrative staff will make scheduled observation visits to each group home to ensure staff are following training. (Please see attached Observation Checklist)	01/24/2022

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	back on the plunger. HM #1 indicated there were 16 ml (milliliters) of fluid in the syringe. HM #1 proceeded with a water flush of 30 ml. HM #1 did not check client #1's g-tube for placement before administering the water flush. HM #1 stated, "We check placement with the stethoscope before feeding. We put 20 ml of air into the g-tube and listen to make sure air is going through, and it's not blocked." HM #1 administered a formula feeding of 90 ml, and a water flush of 30 ml. HM #1 removed the syringe and replaced the cap on client #1's g-tube. Licensed Practical Nurse (LPN) #1 was interviewed on 1/3/22 at 12:51 pm and stated, "Staff should check the g-tube for residual and placement before beginning a feeding or med (medication) pass. They listen for placement and pull back to check for residual." The facility's Bureau of Developmental Disabilities Services (BDDS) reports and related investigations were reviewed on 1/3/22 at 11:21 am. 2. A BDDS report dated 9/24/21 indicated the following: "On Friday 9/24/21 SGL (supported group living) staff called agency nurse to report that [client #1's] g-tube (gastrostomy tube) was clogged, and they had been unsuccessful on getting it unclogged. They continued to work on it until 2 pm. Agency nurse instructed staff that [client #1] would need to be sent out to the ER (emergency room) for further evaluation of g-tube. Once at group home SGL staff was waiting on another staff to arrive at group home, so [client #1] could be taken to the ER per g-tube clog. Whilst awaiting, SGL staff continued to try methods to unclog his g-tube and was successful. [Client #1]			

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	missed his afternoon medications and staff were not able to make them up. Agency nurse was off for the weekend, and SGL staff did not alert the agency nurse until Tuesday upon returning to the office that he never did receive his afternoon medications due to the issues with the g-tube. [Client #1's] g-tube has had no further issues." 3. A BDDS report dated 10/23/21 indicated the following: "On 10/23/21 SGL staff were administering [client #1's] medications via g-tube. During administration, [client #1's] g-tube became clogged. SGL staff reached out to agency nurse for further instruction. SGL staff and agency nurse exhausted all options to get the g-tube unclogged without success.... SGL staff met [client #1] at the ER and stayed with him until discharged. While at the ER, the doctor evaluated the g-tube clog. Due to the severity of clog, the doctor ordered for [client #1's] g-tube to be changed. [Client #1] received a new g-tube without issue. The doctor then ordered and completed an x-ray with contrast to make sure the g-tube was in the correct placement. No abnormal findings noted...." 4. A BDDS report dated 10/30/21 indicated the following: "RN (Registered Nurse) received call from [DSP #3], unable to successfully complete g-tube feeding. Administered 3 ozs (ounces) of water w (with)/success but unable to push feeds. Tubing is clear w/liquid present. Reports she has tried multiple flushes. No fluids in or out and unable to hear placement. 12:45 pm - still no success. 13:30 - no changes. Call placed to QIDP (Qualified Intellectual Disabilities Professional), need for ER evaluation. QIDP advised staffing situation,			

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	transport to hospital for evaluation. 13:45 - [DSP #3] notified of above and will call for transport when staff arrive to accompany client. 13:45 - Call placed to mother, notified of above. 14:20 - House team lead notified. 14:45 - Transport completed by EMS (Emergency Management Services) to [name of hospital]. 17:00 - House team lead contacted, reports that client completed tubing change. Hospital plans to d/c (discharge) to home. Advised to proceed with 'all liquid medications moving forward as white beads from meds (medications) stuck at bottom of tubing causing clogging.' 19:15 - Received call from [house team lead], [client #1] is home." LPN #1 was interviewed on 1/3/22 at 12:51 pm and stated, "The first time, the g-tube was really old. It was clogged up from buildup. After it was changed, I believe staff aren't doing one med (medication) at a time. They're not letting the meds dissolve properly, and it got clogged up. This is a new tube. It should not be happening if they're doing things correctly." LPN #1 stated, "We've gone over how to do it, but I haven't done a formal training. We went over the risk plans and dining." This deficiency was cited on 9/1/21. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-3(a)			
W 0210 Bldg. 00	483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation			

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	conducted prior to admission. Based on record review and interview for 2 of 3 sample clients (#1 and #2), the facility failed to ensure clients #1 and #2 had Comprehensive Functional Assessments (CFAs) completed within 30 days of admission. Findings include: 1. Client #1's record was reviewed on 1/3/22 at 12:00 pm. Client #1's record indicated an admission date of 3/26/21. Client #1's record did not include a CFA. 2. Client #2's record was reviewed on 1/3/22 at 12:15 pm. Client #2's record indicated an admission date of 10/23/20. Client #2's record did not include a CFA. Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 1/3/22 at 12:23 pm and stated, "The CFA's have not been completed. I have not scheduled them yet." QIDP #1 stated, "It should be done 30 days after admission and annually after that." Corporate Complaint and Quality Assurance Director (CCQAD) #1 was interviewed on 1/3/22 at 12:32 pm and stated, "The CFA should be completed within 30 days of admission and every year." This deficiency was cited on 9/1/21. The facility failed to implement a systemic plan of correction to prevent reoccurrence. 9-3-4(a)	W 0210	It is a requirement that the QIDP complete CFA's for all clients within 30 days of admission. Beginning 01/19/2022, Director of Residential Services will schedule and attend all 30 day meetings. DRS will assist QIDP in completing the CFA prior to the ISP meeting, and completing all necessary documentation within 48 hours of the meeting	01/19/2022

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W 0226 Bldg. 00	483.440(c)(4) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must prepare, for each client, an individual program plan. Based on record review and interview for 2 of 3 sample clients (#1 and #2), the facility failed to develop Individual Support Plans (ISPs) for clients #1 and #2 within 30 days of admission. Findings include: 1. Client #1's record was reviewed on 1/3/22 at 12:00 pm. Client #1's record indicated an admission date of 3/26/21. Client #1's record did not include an ISP. 2. Client #2's record was reviewed on 1/3/22 at 12:15 pm. Client #2's record indicated an admission date of 10/23/20. Client #2's record did not include an ISP. Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 1/3/22 at 12:23 pm and stated, "The ISPs just haven't been done. I didn't schedule them yet." QIDP #1 stated, "The ISP should be updated annually and within 30 days of admission." Corporate Complaint and Quality Assurance Director (CCQAD) #1 was interviewed on 1/3/22 at 12:32 pm and stated, "The ISP should be done within 30 days of admission. They are updated at least every year. They (Interdisciplinary Team (IDT)) meet quarterly, so it could be updated then." This deficiency was cited on 9/1/21. The facility	W 0226	It is a requirement that the QIDP completes ISPs within 30 days of admission. Beginning 01/19/2022, Director of Residential Services will schedule and attend all 30 day meetings. DRS will assist QIDP in completing all necessary paperwork within 48 hours	01/19/2022

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	failed to implement a systemic plan of correction to prevent recurrence. 9-3-4(a)			
W 0252 Bldg. 00	483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. Based on record review and interview for 1 of 3 sampled clients (#3), the facility failed to ensure client #3's goals were implemented and recorded as indicated in his Individual Support Plan (ISP). Findings include: Client #3's record was reviewed on 1/3/22 at 12:30 pm. Client #3's ISP dated 9/8/21 indicated the following: "Goal/Service: [Client #3] will complete a cycle of laundry 1x weekly. Goal/Service: [Client #3] will have a positive interaction with staff or peers for 5 minutes 3x a week. Goal/Service: [Client #3] will help balance his checkbook 1x a week. Goal/Service: [Client #3] will clean his bedroom 1x per week. Goal/Service: [Client #3] will 'pop' his medications. Goal/Service: [Client #3] will brush his teeth for 2 1/2 minutes 3x daily. Goal/Service: [Client #3] will assist staff in preparing 1 meal per week. Goal/Service: [Client #3] will take a complete shower every other day." - The review did not include documentation of any goals being recorded in September, October,	W 0252	It is a requirement that all SGL staff provide active treatment and goal documentation for all clients served. Beginning 01/21/22 Managers, QIDP, and DRS will monitor the implementation of goals at least 1x weekly via Therap programmatic reports. Reports will be run by all managers each Monday, and by the QIDP and DRS each Friday. If necessary, disciplinary action will be taken for failure to perform/document client ISP goals	01/21/2022

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	November, or December 2021. Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 1/3/22 at 12:23 pm and stated, "The goals are not being recorded. Staff have been retrained several times, but it's not being done." QIDP #1 stated, "Documentation should be done daily." Corporate Complaint and Quality Assurance Director (CCQAD) #1 was interviewed on 1/3/22 at 12:32 pm and stated, "Staff should run the goals based on the ISP and document them on [digital record keeping system]. The instructions should be there (in the ISP) as well to tell them when and how to implement and run the goal." This deficiency was cited on 9/1/21. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-4(a)			